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CLASSIFYING AND DIAGNOSING ABNORMALITY

Carla is intelligent, but she is failing her first period class in biology because she is either late to class or absent. She gets up at five o'clock, hoping to get to school on time. The next three hours are spent taking a long shower followed by changing clothes repeatedly until it "feels right." She finally packs and repacks her books until they are just right, opens the front door and prepares to walk down the front steps. She goes through a ritual of pausing on each step for a particular length of time. Even though she recognizes her thoughts and behaviors are senseless, she feels compelled to complete her rituals. Once she has completed these rituals, she makes a mad dash for school and arrives when first period is almost over.

Joe is born six weeks early, but is healthy, and leaves the hospital two weeks later. He grows into a happy boy with a healthy appetite. He loves being outside and plays sport at every opportunity. Just before his twelfth birthday Joe starts to become even more serious about his sport. His muscles quickly become clearly defined and Joe's friends at school praise him over his new found physique. Even his mum has to admit he looks in fine shape. Joe feels on top of the world. He is the best footballer and cross-country runner in his year group and he intends to stay that way. Unfortunately Joe's euphoria is short lived. Each day Joe finds he wants to exercise a little more and eat a little less. This soon has a dramatic effect on his weight. Joe loses a quarter of his body weight in four months, falling from 42kg (6 stone 8 lbs) to just 31.4kg (4 stone 13 lbs). When he reaches 37kg his mum takes him to the doctor for the first time but is told not to fuss. Joe has several more visits to the doctor before being finally referred on to a specialist. It is a painfully slow process. Meanwhile Joe's behaviour changes. He becomes distant from his friends. He can't concentrate at school. He becomes angry and aggressive if anyone challenges him about his weight or his diet.

The above case study of Carla and Joe show different traits of abnormal behavior. Now we turn to a discussion of what we mean by the term abnormal behavior. One of the more difficult challenges facing those in the field of abnormal psychology is to define **abnormal behavior.**

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DEFINING AND PROBLEMS IN DEFINING ABNORMALITY

Any individual who fails to function adequately is seen as being abnormal. Sue et al, (1994) use the terms practical or clinical criteria to describe the ways in which people fail to function adequately since, as Buss (1996) has noted, they are often the basis on which people come to the attention of psychologists or other interested professionals.

We will consider several characteristics that have been proposed as components of abnormal behavior. Our best definition of abnormal behavior takes into account the characteristics of statistical infrequency, violation of norms, personal distress, disability or dysfunction, and unexpectedness.

STATISTICAL INFREQUENCY:

One aspect of abnormal behavior is that it is infrequent. Statistical infrequency is used explicitly in diagnosing mental retardation. Though a number of criteria are used to diagnose mental retardation, low intelligence is a principal one. When an individual's IQ is below 70, his or her intellectual functioning is considered sufficiently sub-normal to be designated as mental retardation.

Although some infrequent behaviors or characteristics of people do strike us as abnormal, in some instances the relationship breaks down. Having great athletic ability is infrequent, but few would regard it as part of the field of abnormal psychology. Unfortunately, the statistical component gives us little guidance in determining which infrequent behaviors psychopathologists should consider.

VIOLATION OF NORMS:

Another characteristic to consider when determining abnormality is whether the behavior violates social norms or threatens or makes anxious those observing it. Violation of norms explicitly makes abnormality a relative concept; various forms of unusual behavior can be tolerated, depending on the prevailing cultural norms.

Criminals and prostitutes violate social norms but are not usually studied within the domain of abnormal psychology; and the highly anxious person, who is generally regarded as a central character in the field of abnormal psychology, typically does not violate social norms and would not be bothersome to many lay observers. In addition cultural diversity can affect how people view social norms - what is the norm in one culture may be abnormal in another.

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PERSONAL DISTRESS:

Another characteristic of some forms of abnormality is personal suffering; that is, behavior is abnormal if it creates great distress and torment in the person experiencing it. Personal distress clearly fits many of the forms of abnormality considered in this syllabus- people experiencing anxiety disorders and depressions truly suffer greatly.

Not all forms of distress for example, hunger or the pain of childbirth seem to belong to the field.

DISABILITY OR DYSFUNCTION:

Disability, that is, whether the individual is impaired in some important area of life (e.g., work or personal relationships) because of the abnormality, can also be a component of abnormal behaviour. Substance-use disorders are also defined in part by the social or occupational disability (e.g., poor work performance, serious arguments with one's spouse) created by substance abuse.

Other characteristics that might in some circumstances be considered disabilities - such as being short if you be a professional basketball player- do not fall within domain of abnormal psychology. As with distress, we not have a rule that tells us which disabilities belong and which do not.

UNEXPECTEDNESS:

Distress and disability are considered abnormal when they are unexpected responses to environmental stressors (Wakefield, 1992). For example, an anxiety disorder is diagnosed when the anxiety is unexpected and out of proportion to the situation, as when a person who is well off worries about his or her financial situation.

But many people experience some life stress without developing psychological problem.

It is clear that all the definitions of abnormality we have discussed have both good and bad points. All are helpful as ways of conceptualizing abnormality, but none on its own is sufficient as a definition of abnormality, but together they offer a useful framework for beginning to define abnormality.

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DIAGNOSING (CLASSIFYING) AND PROBLEMS OF DIAGNOSING ABNORMALITY

By the end of the nineteenth century medicine had progressed far beyond its practice during the Middle Ages when bloodletting was at least part of the treatment of virtually all physical problems. Gradually people recognized that different illnesses required different treatments. Diagnostic procedures were improved, diseases classified, and applicable remedies administered. Impressed by the successes that new diagnostic procedures had achieved in the field of medicine, investigators of abnormal behavior also sought to develop classification schemes. Unfortunately, progress in classifying mental disorders was not to be easily gained.

In the field of mental health, classification involves the identification of similarities and differences among the behavioral abnormalities manifested by people. One approach to classification is the categorical approach, in which behavioral symptoms that tend to occur together are assigned to a category. Guidelines for diagnosis are then based on symptom criteria. This is currently the dominant way of classifying mental disorders around the world. Taking this approach, a person either does or does not meet clinical criteria for a specific psychological disorder, such as depression. In order to meet the clinical criteria, the key symptoms must be present, and they must meet a specific threshold for severity. Thus, if the feeling of sadness is not severe enough, it will not meet the clinical criterion for that symptom and the person may not meet the overall criteria for depression. This person's symptoms would be viewed as sub clinical, or below the threshold for a diagnosis.

The sorting of people into categories so that their behaviour may be predicted is not new. The first person to attempt a unified classification of abnormal states was the Ancient Greek physician **Hippocrates**. Hippocrates identified three categories of abnormal behavior.

Attempts beginning a classificatory system were made by the pioneer reformer **Philip Pinel**, who grouped disorders he believed were psychological or mental in nature into a category he called neurosis (defined as functional diseases of the nervous system) and divided these into several types.

The first comprehensive attempt to classify abnormal behaviors was developed by **Emil Kraepelin** who, in 1913, published a classificatory system that brought together earlier systems and at the same time elaborated on them in important ways. After carefully observing hospitalized patients and examining their records, Kraepelin suggested that there were eighteen distinct types of mental disorders, each of which had a

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characteristic pattern of symptoms (which Kraepelin termed a syndrome), a distinct course of development, particular underlying physical causes and a characteristic outcome.

Kraepelin's work was important in the development of two classificatory systems which were introduced after the Second World War. In 1948, the World Health Organization (WHO) was created and shortly afterwards, published the International Standard Classification of Diseases, Injuries and Causes of Death (ICD). The ICD was a manual that provided a classification of all diseases and disorders, including those the WHO considered to be psychological in nature. Independently, and at around the same time the American Psychiatric Association (1952) published the first edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM), which contained a classification of mental disorders based on a scheme developed by the US Army in World War II.

One of the most widely used diagnostic systems for mental disorders is the Diagnostic and Statistical Manual of Mental Disorders (DSM). In 1952, the DSM was developed in the United States, and approved by the American Psychiatric Association. Since then, the DSM has been revised and expanded several times with the goal of improving its accuracy. One of the most extensive revisions took place in 1968, when the DSM was replaced by DSM-II. The diagnostic categories in DSM-II were highly influenced by the psychoanalytic theory. But the diagnosis that were made using DSM-II were problematic; when asked to diagnose a troubled person using the DSM-II categories, diagnosticians had difficulty agreeing with each other (**Back, Ward, Mendelson, Mock, and Erbaught, 1962; Rosenhan, 1975; Spitzer, 1975**). As a result of these concerns, DSM-III was published in 1980. The diagnostic categories in DSM-III included more objective descriptions of behaviors, rather than inferred traits. Moreover, the number of diagnostic categories was expanded, from fewer than one hundred in DSM-II to well over two hundred in DSM-III, Because of continuing reliability problems, however, DSM-III was replaced by DSM-III-R (for revised) in 1987. It began as an attempt to fine-tune DSN-III, but it ended up as a major revision. Finally, DSM-III-R was replaced by DSM-IV in 1994. While touted as being based on empirical efforts (**Blissfield and Livesley, 1991; Widiger, Frances, Pincus, Davis, and First, 1991**), well-informed authorities consider that it relies mainly on expert opinion (**Spitzer, 1991**) and may continue to have the same problems with diagnosis as did its predecessors.

In DSM-IV, a mental disorder is defined as a behavioral or psychological pattern that has either caused the individual distress or disabled the individual in one or more significant areas of functioning. Beyond defining mental disorder, DSM-IV seeks to provide specific and operational (that is, clearly stated and reproducible) diagnostic criteria for each mental disorder.

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The major diagnostic categories of DSM-IV are as follows:

DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY CHILDHOOD, OR ADOLESCENCE:

Within this broad-ranging category are the intellectual, emotional, and physical disorders that usually begin in infancy, childhood, or adolescence.

- The child with separation anxiety disorder has excessive anxiety about being away from home or parents.
- Children with conduct disorder repeatedly violate social norms and rules.
- Individuals with attention-deficit/hyperactivity disorder have difficulty sustaining attention and are unable to control their activity when the situation calls for it.
- Individuals with mental retardation show subnormal intellectual functioning and deficits in adaptive functioning.
- The pervasive developmental disorders include autistic disorder, a severe condition in which the individual has problems in acquiring communication skills and deficits in relating to other people.
- Learning disorders refer to delays in the acquisition of speech, reading, arithmetic, and writing skills.

SUBSTANCE-RELATED DISORDERS:

A substance-related disorder is diagnosed when the ingestion of some substance-alcohol has changed behavior enough to impair social or occupational functioning. The individual may become unable to control or discontinue ingestion of the substance and may develop withdrawal symptoms if he or she stops using it. These substances may also cause or contribute to the development of other disorders, such as those of mood or anxiety.

SCHIZOPHRENIA:

For individuals with schizophrenia contact with reality is faulty. Their language and communication are disordered, and they may shift from one subject to another in ways that make them difficult to understand. They commonly experience delusions, such as believing that thoughts that are not their own have been placed in their heads. In addition, they are some times plagued by hallucinations, in particular, hearing voices that come from outside themselves. Their emotions are blunted, flattened, or inappropriate, and their social relationships and ability to work have markedly deteriorated.

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MOOD DISORDERS:

As the name implies, these diagnoses are applied to people whose moods are extremely high or low.

- ☹ In major depressive states the person is deeply sad and discouraged and is also likely to lose weight and energy and to have social thoughts and feelings of self-reproach.

- ☺ The person with mania may be described as exceedingly euphoric, irritable, more active than usual and distractible.

- 😐 Bipolar disorder is diagnosed if the person experiences episodes of mania or of both mania and depression.

ANXIETY DISORDERS:

Anxiety disorders have some form of irrational or overblown fear as the central disturbance.

- Individuals with a phobia fear an object or situation so intensely that they must avoid it, even though they know that their fear is unwanted and unreasonable and disrupts their life.

- In panic disorder the person is subject to sudden but brief attacks of intense apprehension, so upsetting that he or she in likely to tremble and shake, feel dizzy and have trouble breathing. Panic disorder may be accompanied by agoraphobia, when the person is also fearful of leaving familiar surroundings.

- 😐 In people diagnosed with generalized anxiety disorder, fear and apprehension are pervasive, persistent, and uncontrollable. They worry constantly, feel generally on edge, and are easily tired.

- A person with obsessive-compulsive disorders is subject to persistent obsessions or compulsions. An obsession is a recurrent thought, idea, or image that uncontrollably dominates a person's consciousness. A compulsion is an urge to perform a stereotyped act with the usually impossible purpose of warding off an impending feared situation. Attempts to resist a compulsion create so much tension that the individual usually yields to it.

- Experiencing anxiety and emotional numbness in the aftermath of a very traumatic event is called posttraumatic stress disorder. Individuals have painful, intrusive recollections by day and bad dreams at night. They find it difficult to concentrate and feel detached from others and from ongoing affairs.

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- Acute stress disorder is similar to posttraumatic stress disorder, but the symptoms do not last as long.

SOMATOFORM DISORDERS:

The physical symptoms of somatoform disorders have no known physiologic cause but seem to serve a psychological purpose.

- Persons with summarization disorder have a long history of multiple physical complaints for which they have taken medicine or consulted doctors.
- In conversion disorder the person reports the loss of motor or sensory function, such as a paralysis, and anesthesia (loss of sensation), or blindness.
- Individuals with pain disorder suffer from severe and prolonged pain.
- Hypochondriasis is the misinterpretation of minor physical sensations as serious illness.
- People with body dysmorphic disorder are preoccupied with an imagined defect in their appearance.

DISSOCIATIVE DISORDERS:

Psychological dissociation is a sudden alteration in consciousness that affects memory and identity.

- Persons with dissociative amnesia may forget their entire past or lose memory for a particular time period.
- With dissociative fugue the individual suddenly and unexpectedly travels to a new locale, starts a new life, and is amnesic for his or her previous identity.
- The person with dissociative identity disorder (formerly called multiple personality disorder) possesses two or more distinct personalities, each complex and dominant one at a time.
- Depersonalization disorder is a severe and disruptive feeling of self-estrangement or unreality.

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SEXUAL AND GENDER IDENTITY DISORDERS:

The sexual disorders section of the DSM lists three principal subcategories.

- In paraphilias the sources of sexual gratification are unconventional.
- Persons with sexual dysfunctions are unable to complete the usual sexual response cycle.
- People with gender identity disorder feel extremely discomfort with their sex and identify themselves as members of the opposite sex.

SLEEP DISORDER:

Two major subcategories of sleep disorders are distinguished in DSM-IV-TR.

- In the dyssomnias, sleep is disturbed in amount (e.g., the person is not able to maintain sleep or sleeps too much), quality (the person does not feel rested after sleep), or timing (e.g., the person experiences inability to sleep during conventional sleep times).
- In the parasomnias, an unusual event occurs during sleep (e.g., nightmares, sleepwalking)

EATING DISORDERS:

Eating disorders fall into two major categories.

- In anorexia nervosa the person avoids eating and becomes emaciated, usually because of an intense fear of becoming fat.
- In bulimia nervosa there are frequent episodes of binge eating coupled with compensatory activates such as self-induced vomiting and heavy use of laxatives.

FACTITIOUS DISORDER:

A diagnosis of factitious disorder is applied to people who intentionally produce or complain of physical or psychological symptoms, apparently because of a psychological need to assume the role of a sick person.

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ADJUSTMENT DISORDERS:

An adjustment disorder involves the development of emotional or behavioral symptoms following the occurrence of a major life stressor.

IMPULSE CONTROL DISORDER:

Impulse control disorders include a number of conditions in which the person's behavior is inappropriate and seemingly out of control.

- In intermittent explosive disorder the person has episodes of violent behavior that result in destruction of property or injury to another person.
- In kleptomania the person steals repeatedly, but not for the monetary value of the object or for the use of the object.
- In pyromania the person purposefully sets fires and derives pleasure from doing so.
- In pathological gambling the person is preoccupied with gambling, is unable to stop, and gambles as a way to escape from problems.
- Trichotillomania is diagnosed when the person can not resist the urge to pluck out his or her hair, often resulting in significant hair loss.

PERSONALITY DISORDERS:

Personality disorders are defined as enduring, inflexible, and maladaptive patterns of behavior and inner experience.

- In schizoid personality disorder the person is aloof, has few friends, and is indifferent to praise and criticism.
- The individual with a narcissistic personality disorder has an overblown sense of self-importance, fantasizes about great successes, requires constant attention, and is likely to exploit others.
- Antisocial personality disorder surfaces as conduct disorder before the person reaches age fifteen running away from home, delinquency, in adulthood the person is indifferent abut holding a job, being a responsible partner or parent, planning for the future or even for tomorrow, and staying on the right side of the law. People with antisocial personality disorder-also called psychopathy- do not feel guilt or shame for transgressing social mores.

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OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION:

This all-encompassing category comprises conditions that are not regarded as mental disorders but still may be a focus of attention or treatment. This category seems to exist so that anyone entering the mental health system can be categorized, even in the absence of a formally designated mental disorder.

If an individual's medical illness appears to be caused in part or exacerbated by a psychological condition, the diagnosis is psychological factors affecting physical condition. Among the other diagnoses in this category are the following:

- Academic problem (e.g., underachievement)
- Antisocial behavior (e.g., in profession thieves)
- Malingering (faking physical or psychological symptoms to achieve a goal, such as avoiding work)
- Relational problem (e.g., poor relationship with sibling or spouse)
- Occupational problem (e.g., dissatisfaction with work)
- Physical or sexual abuse
- Bereavement
- Noncompliance with treatment (e.g., refusing medication)
- Religious or spiritual problem (e.g., questioning one's faith)
- Phase-of-life problem (difficulties created by a life transition, such as beginning school)

DELIRIUM, DEMENTIA, AMNESTIC, AND OTHER COGNITIVE DISORDERS:

This category covers disorders in which cognition is seriously disturbed.

- Delirium is a clouding of consciousness, wandering attention, and an incoherent stream of thought. It may be caused by several medical conditions such as malnutrition as well as by substance abuse.
- Dementia, a deterioration of mental capacities, especially memory, is associated with Alzheimer's disease, stroke, and several other medical conditions as well as with substance abuse.
- Amnestic syndrome is impairment in memory when there is no delirium or dementia.

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Both the ICD and DSM classificatory systems have undergone several revisions since their introduction. The most recent revision of the ICD is the tenth (ICD 10). The Clinical Descriptions and Diagnostic Guidelines of the ICD-10 were published in 1991.

ICD- 10 identifies eleven major categories of mental disorder. Following are major categories of it and some specific examples of disorders included in those categories.

ORGANIC, INCLUDING SYMPTOMATIC, MENTAL DISORDERS:

- Dementia in Alzheimer's disease
- Organic amnesic syndrome
- Personality and behavioral disorders due to brain disease, damage and dysfunction

MENTAL AND BEHAVIOURAL DISORDERS DUE TO PSYCHOACTIVE SUBSTANCE USE:

Substances include alcohol, cocaine and hallucinogens.

SCHIZOPHRENIA, SCHIZOTYPAL AND DELUSIONAL DISORDERS:

- Schizophrenia
- persistent delusional disorders

MOOD (AFFECTIVE) DISORDERS:

- manic episode (including hypomania)
- bipolar affective disorders
- depressive episode
- recurrent depressive disorder
- persistent mood (affective)

NEUROTIC, STRESS-RELATED AND SOMATOFORM DISORDERS:

- phobic anxiety disorders (social phobias and specific (isolated) phobias)
- anxiety disorders (including panic disorder, generalized anxiety disorder)
- obsessive adjustment disorders (including post-traumatic stress disorders)
- dissociative (conversion) disorders (including dissociative amnesia, fugue and multiple personality disorder);
- somatoform disorders (including hypochondriacal disorders)

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BEHAVIOURAL SYNDROMES ASSOCIATED WITH PHYSIOLOGICAL DISTURBANCES AND PHYSICAL FACTORS:

- eating disorders (including anorexia nervosa and bulimia nervosa)
- non-organic sleep disorders (including sleep-walking, night terrors)
- sexual dysfunction not caused by organic disorder or disease

DISORDERS OF ADULT PERSONALITY AND BEHAVIOUR:

- Specific personality disorders
- Habit and impulse disorders (including pathological gambling fire setting and stealing)
- Gender and identity disorders (including transsexuals)
- Disorders of sexual preference.

MENTAL RETARDATION:

Mental retardation which mild, moderate, severe or profound.

DISORDERS OF PSYCHOLOGICAL DEVELOPMENT:

- Specific disorders of speech and language
- Specific developmental disorders of scholastic skills (including disorders of reading, spelling, arithmetic and scholastic skills)
- Pervasive developmental disorder
-

BEHAVIOURAL AND EMCTIONAL DISORDERS WITH ONSET USUALLY OCCURRING IN CHILDHOOD AND ADOLESCENCE:

Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence.

UNSPECIFIED MENTAL DISORDER:

Mental disorder not otherwise specified.

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In judging abnormal behavior, however, we cannot so easily decide what is wheat and what is chaff, for the relevant and irrelevant dimensions of abnormal behavior are uncertain. Thus when we do classify, we may be grouping people together on rather trivial basis while ignoring their extremely important differences.

Currently available tests and diagnostic procedures for assessing mental disorders have limitations. Because the diagnosis of mental disorders relies so heavily on behavioral signs, there is much room for error. But can we do without diagnosis? Absolutely not. There can be no science, and no advance in understanding psychological abnormality, without somehow differentiating one kind of syndrome from another. By differentiating a behavioral syndrome associated with one disorder from other mental disorders researchers ultimately made the treatment break through possible. Without diagnosis, advances in treatment would not have been possible.

Classification may also have negative effects on a person. Consider how your life might be changed after being diagnosed as having schizophrenia. You might become guarded and suspicious lest someone recognize your disorder. Or you might be chronically on edge, fearing the onset of another episode. The fact that you are a "former mental patient" could have a stigmatizing effect. Friends and loved ones might treat you differently, and employment might be difficult to obtain.

There is little doubt that diagnosis can have such negative consequences. It is clear from the existing research that the general public holds a very negative view of mental patients and that patients and their families believe that such stigmatizing effects are common (Rabkin, ,1974 & Harrman, 1989).

Assuming that various types of abnormal behavior do differ from one another, classifying them is essential, for these differences may constitute keys to the causes and treatments of various deviant behaviors.

Forming categories may thus further knowledge, for once a category is formed, additional information may be ascertained about it. Even though the category is only an asserted, and not a proved, entity, it may still be heuristically (discover) useful in that it facilitates the acquisition of new information. Only after a diagnostic category has been formed can people who fit its definition be studied in the hope of uncovering factors responsible for the development of their problems and of devising treatments that may help them. For example, only a few decades ago, bipolar disorder (episodes of both mania and depression) was not typically distinguished from depression.

Prior to DSM-III, reliability was not acceptable, mainly because the criteria for making a diagnosis were not presented clearly and methods of assessing a patient's symptoms were not standardized (Ward et al., 1962).

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Much more attention is now paid to how the symptoms of a given disorder may differ depending on the culture in which it appears. For example, it is known that the core symptoms of both schizophrenia (e.g., delusions, and hallucinations) and depression (e.g., depressed mood and loss of interest or pleasure in activities) are similar cross-culturally (Draguns, 1989). However, guilt is a frequent symptom of depression in Western society but an infrequent symptom in Japan and Iran. Interpreting the meaning of cross-cultural differences in mental disorder may prove to be the most challenging aspect of this research. But investigators cannot abandon the problem.

In the context of classificatory systems of abnormal behaviour, reliability refers to the consistency of a diagnosis across preheated measurements. Clearly, no system of classification is of any value unless users of it can agree with one another when trying to reach a diagnosis. A study conducted by Zigler & Phillips (1961) reported a range of 54-84% agreement in studies assessing reliability for broad categories of disorders. However, Kendell (1975) showed that when more differentiated categories were used (such as specific types of anxiety), reliability ranged from 32-57%.

Both DSM-IV and ICD-10 appear to be much more reliable than their predecessors, and as far as ICD-10 is concerned, Sartorius et al. (1993) have concluded that its clinical guidelines are suitable for widespread international use because of their high reliability.

Validity refers to an estimation of the accuracy of a particular measure, in this context, validity is the extent which a diagnosis reflects an actual disorder. Validity is much more difficult to assess. As Holmes (1994) has observed, there is no guarantee that a person has received the 'correct' diagnosis.

Indeed in a study conducted by Bannister et al. (1964) of 1,000 cases, there was no clear-cut relationship between the diagnoses people wee given and the treatment they received (and one reason for this is that factors other than diagnosis may be equally important in deciding on a particular treatment).

Critics of diagnostic systems have argued that the diagnostic process cannot be valid if the label a person is given does not allow a clinician to make a judgment abut the cause of the disorder or a prediction about prognosis and likely response to treatment.

Not all the DSM classification changes seem positive. Should a problem such as difficulty in learning arithmetic or reading be considered a psychiatric disorder? By expanding its coverage the DSM seems to have made too many childhood problems into psychiatric disorders, without good justification for doing so.

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Although it is wise to take a critical approach to the diagnosis of mental disorders we must not forget that there are limits on diagnostic reliability in virtually all fields of medicine. Over time, as scientific research progresses, we come to understand which diagnoses are useful and which are to. Similar break through in diagnosis have occurred in the treatments of many physical disorder. As researchers have systematically examined symptoms and syndromes of physical disorders, they have discovered new and important distinctions.

In sum, although the DSM is continually improving it is far from perfect. What is most heartening about the DSM is that its attempts to be explicit about the rules for diagnosis make it easier to detect problems in the diagnostic system. We can expect more changes and refinements over the next several years.

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